

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0047589

Facility Name: Vandalia Rehabilitation & Health Care Center

Address: 1500 West St Louis Avenue Vandalia 62471
Number City Zip Code

County: Fayette

Telephone Number: 618-283-4262 Fax # 618-283-4313

HFS ID Number: 20-3224201004

Date of Initial License for Current Owners: 10/01/2005

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover Telephone Number: 312-634-4581
Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date) _____
(Print Name and Title) _____
(Firm Name & Address) McGladrey & Pullen, LLP
One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Vandalia Rehabilitation & Health Care Center

0047589 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>57</u>	Skilled (SNF)	<u>57</u>	<u>20,805</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>59</u>	Intermediate (ICF)	<u>59</u>	<u>21,535</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>116</u>	TOTALS	<u>116</u>	<u>42,340</u>	7

B. Census-For the entire report period.					
	1	2	3	4	5
	Level of Care	Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF			<u>3,217</u>	<u>3,217</u>
9	SNF/PED				
10	ICF	<u>14,815</u>	<u>3,920</u>		<u>18,735</u>
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	<u>14,815</u>	<u>3,920</u>	<u>3,217</u>	<u>21,952</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.85%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 10/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 10/01/05 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 57 and days of care provided 3,217

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number

Vandalia Rehabilitation & Health Care Center

#

0047589

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total			7**	8	9	10	
	A. General Services	1	2	3	4	5	6					
1	Dietary	124,985	13,668	2,887	141,540		141,540	2,181	143,721			1
2	Food Purchase		86,779		86,779		86,779	(7,551)	79,228			2
3	Housekeeping	90,733	15,550		106,283		106,283	70	106,353			3
4	Laundry	22,781	12,736		35,517		35,517		35,517			4
5	Heat and Other Utilities			99,983	99,983		99,983	290	100,273			5
6	Maintenance	34,852	33,924	14,965	83,741		83,741	5,408	89,149			6
7	Other (specify):*							1,359	1,359			7
8	TOTAL General Services	273,351	162,657	117,835	553,843		553,843	1,757	555,600			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	949,577	271,927	5,157	1,226,661		1,226,661	6,737	1,233,398			10
10a	Therapy		2,984	230,023	233,007		233,007	518	233,525			10a
11	Activities	23,752	4,341	3,416	31,509		31,509		31,509			11
12	Social Services	56,725	155		56,880		56,880		56,880			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,120	2,120			15
16	TOTAL Health Care and Programs	1,030,054	279,407	246,596	1,556,057		1,556,057	9,375	1,565,432			16
	C. General Administration											
17	Administrative	57,197		58,000	115,197		115,197	(41,312)	73,885			17
18	Directors Fees											18
19	Professional Services			5,454	5,454		5,454	9,560	15,014			19
20	Dues, Fees, Subscriptions & Promotions			4,466	4,466		4,466	1,601	6,067			20
21	Clerical & General Office Expenses	37,091	9,098	22,133	68,322		68,322	31,109	99,431			21
22	Employee Benefits & Payroll Taxes			234,288	234,288		234,288	3,361	237,649			22
23	Inservice Training & Education			794	794		794	201	995			23
24	Travel and Seminar							806	806			24
25	Other Admin. Staff Transportation			7,879	7,879		7,879	2,367	10,246			25
26	Insurance-Prop.Liab.Malpractice			16,698	16,698		16,698	1,238	17,936			26
27	Other (specify):*							6,039	6,039			27
28	TOTAL General Administration	94,288	9,098	349,712	453,098		453,098	14,970	468,068			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,397,693	451,162	714,143	2,562,998		2,562,998	26,102	2,589,100			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7**	8			
30	Depreciation			41,304	41,304		41,304	6,493	47,797			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,721	64,721		64,721	18,229	82,950			32
33	Real Estate Taxes			30,325	30,325		30,325	2,169	32,494			33
34	Rent-Facility & Grounds							988	988			34
35	Rent-Equipment & Vehicles			189,945	189,945		189,945	645	190,590			35
36	Other (specify):*											36
37	TOTAL Ownership			326,295	326,295		326,295	28,524	354,819			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,386	22,448	31,834		31,834		31,834			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,336	63,336		63,336		63,336			42
43	Other (specify):* Nonallowable Cost			157,604	157,604		157,604	(157,604)				43
44	TOTAL Special Cost Centers		9,386	243,388	252,774		252,774	(157,604)	95,170			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,397,693	460,548	1,283,826	3,142,067		3,142,067	(102,978)	3,039,089			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,916)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(818)	30		9
10	Interest and Other Investment Income	(4,316)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(409)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(915)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(135,525)	43		24
25	Fund Raising, Advertising and Promotional	(4,541)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(21,823)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (172,263)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	69,285		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 69,285		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (102,978)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (2,885)	43	1
2	Labs Part A	(5,372)	43	2
3	X-Ray- Part A	(2,454)	43	3
4	Marketing Supplies	(1,588)	43	4
5	Nonallowable Dues	527	20	5
6	Nonallowable travel	(5,778)	24	6
7	Offset meal revenue	(4,273)	2	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(21,823)		49

Summary A

12/31/2006

[illegible]

Summary B

12/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,561	\$ 1,561	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	77	77	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	69	69	3
4	V								4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	290	290	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	3,970	3,970	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	626	626	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,644	5,644	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	518	518	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,745	1,745	10
11	V	17	Administrative	58,000	Petersen Health Care, Inc.	100.00%	15,385	(42,615)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	6,738	6,738	12
13	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	660	660	13
14	Total			\$ 58,000			\$ 37,283	\$ * (20,717)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 24,801	\$ 24,801	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	201	201	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	6,005	6,005	17
18	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,597	1,597	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,182	1,182	19
20	V	27	Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,383	4,383	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	6,115	6,115	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	3,397	3,397	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	717	717	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	695	695	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	364	364	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 49,457	\$ * 49,457	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 620	\$ 620	15
16	V	2	Food		Petersen Health Care, Inc.	100.00%	5	6	16
17	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	1	1	17
18	V								18
19	V								19
20	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,438	1,438	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	733	733	21
22	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,093	1,093	22
23	V								23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	375	375	24
25	V	17	Administrative		Petersen Health Care, Inc.	100.00%	1,303	1,303	25
26	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	2,822	2,822	26
27	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	415	415	27
28	V	21	Clerical & General Office		Petersen Health Care, Inc.	100.00%	6,308	6,308	28
29	V								29
30	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	579	579	30
31	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	770	770	31
32	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	56	56	32
33	V	27	Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,656	1,656	33
34	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	1,196	1,196	34
35	V	32	Interest		Petersen Health Care, Inc.	100.00%	19,148	19,148	35
36	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,452	1,452	36
37	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	293	293	37
38	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	281	281	38
39	Total			\$			\$ 40,544	\$ * 40,545	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.96	1.92	Salary	\$ 15,385	17,7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 15,385		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Vandalia Rehabilitation & Health Care Center**# **0047589**

Report Period Beginning:

01/01/2006Ending: **2/31/2006****VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 West Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,141,463	56	\$ 81,179	\$ 80,967	21,952	\$ 1,561	1
2	2	Food	Patient Days	1,141,463	56	3,989	0	21,952	77	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	0	21,952	69	3
4										4
5	5	Utilities	Patient Days	1,141,463	56	15,054	0	21,952	290	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	21,952	3,970	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	0	21,952	626	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	21,952	5,644	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	0	21,952	518	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	0	21,952	1,745	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	21,952	15,385	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	4,303	21,952	6,738	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325	0	21,952	660	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	21,952	24,801	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	0	21,952	201	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259	0	21,952	6,005	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	0	21,952	1,597	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457	0	21,952	1,182	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912	0	21,952	4,383	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964	0	21,952	6,115	20
21	32	Interest	Patient Days	1,141,463	56	176,614	0	21,952	3,397	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282	0	21,952	717	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	0	21,952	695	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	0	21,952	364	24
25	TOTALS					\$ 4,510,235	\$ 2,239,302		\$ 86,740	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Vandalia Rehabilitation & Health Care Center** # **0047589** Report Period Beginning: **01/01/2006** Ending: **2/31/2006**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Petersen Health Care, Inc.
Street Address 830 West Trailcreek Drive
City / State / Zip Code Peoria, IL 61614
Phone Number (309) 691-8113
Fax Number (309) 691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	427,669	46	\$ 12,081	\$ 11,958	21,952	\$ 620	1
2	2	Food	Patient Days	427,669	46	93	0	21,952	5	2
3	3	Housekeeping	Patient Days	427,669	46	28	0	21,952	1	3
4										4
5										5
6	6	Maintenance	Patient Days	427,669	46	28,012	28,012	21,952	1,438	6
7	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282	0	21,952	733	7
8	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	20,434	21,952	1,093	8
9										9
10	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301	0	21,952	375	10
11	17	Administrative	Patient Days	427,669	46	25,391	25,391	21,952	1,303	11
12	19	Professional Services	Patient Days	427,669	46	54,971	0	21,952	2,822	12
13	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088	0	21,952	415	13
14	21	Clerical & General Office	Patient Days	427,669	46	122,893	64,907	21,952	6,308	14
15										15
16	24	Travel and Seminar	Patient Days	427,669	46	11,280	0	21,952	579	16
17	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003	0	21,952	770	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087	0	21,952	56	18
19	27	Mgmt Allocation of Benefits	Patient Days	427,669	46	32,265	0	21,952	1,656	19
20	30	Depreciation	Patient Days	427,669	46	23,301	0	21,952	1,196	20
21	32	Interest	Patient Days	427,669	46	373,049	0	21,952	19,148	21
22	33	Real Estate Taxes	Patient Days	427,669	46	28,282	0	21,952	1,452	22
23	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700	0	21,952	293	23
24	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479	0	21,952	281	24
25	TOTALS					\$ 789,885	\$ 150,702		\$ 40,544	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 560,000	\$ 551,826	09/20/10	Varies	\$ 49,015	1	
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	110,000	109,799	09/20/10	0.1000	15,706	2	
3												3	
4							Allocation from Home Office				22,545	4	
5							Offset Interest Income				(4,316)	5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 670,000	\$ 661,625			\$ 82,950	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 670,000	\$ 661,625			\$ 82,950	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

16	AMOUNT TO USE FOR RATE CALCULATION \$	
----	---------------------------------------	--

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Vandalia Rehabilitation & Health Care Center

COUNTY

Fayette

FACILITY IDPH LICENSE NUMBER

0047589

CONTACT PERSON REGARDING THIS REPORT

Mark Petersen

TELEPHONE

(309) 691-8113

FAX #:

(309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	<u>Tax</u> Applicable to Nursing Home
1.	18-14-17-453-012	Nursing Home	\$ 30,104.56	\$ 30,104.56
2.		Home Office Allocation	\$	\$ 2,169.00
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 30,104.56	\$ 32,273.56

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,764

B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
N/A

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	159,430	2005	\$ 29,250	1
2					2
3	TOTALS	159,430		\$ 29,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	58		2005	1969	\$ 527,250	\$	25	\$ 21,090	\$ 21,090	\$ 31,635	4
5											5
6	Home Office Allocation			2006	13,092			573	573	573	6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements		2005		13,000		15	867	867	1,300	9
10	Sidewalks		2006		7,967		15	266	266	266	10
11											11
12	Land Impovement Booked					1,176			(1,176)		12
13	Building Booked					21,155			(21,155)		13
14											14
15	Home Office Allocation		2006		778			71	71	71	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.
 See Page 12A, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 562,087	\$ 22,331		\$ 22,867	\$ 536	\$ 33,845	70

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 112,264	\$ 18,972	\$ 17,289	\$ (1,683)		\$ 25,935	71
72	Current Year Purchases	13,907		974	974		974	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			6,667	6,667			74
75	TOTALS	\$ 126,171	\$ 18,972	\$ 24,930	\$ 5,958		\$ 26,909	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 717,508	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,303	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,797	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,494	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 60,754	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ N/A	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Home Office Allocation				988			5
6								6
7	TOTAL				\$988			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.

9. Option to Buy:☐ YES☒ NOTerms: N/A*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?☐ YES☒ NO
16. Rental Amount for movable equipment: \$190,590Description: Dish machine 757; Copier 2433; Nursing Equip 186,755; Home Office 645
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2007	\$
13.	/2008	\$
14.	/2009	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,227	\$ 68,497	\$	1,227	\$ 68,497	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		142	12,276		142	12,276	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)(3)	hrs		1,935	149,768	2,984	1,935	152,752	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				1,384		1,384	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(3)	hrs		374	22,448		374	22,448	12
13	Other (specify): Oxygen	39(2)					8,002		8,002	13
14	TOTAL			\$	3,678	\$ 252,989	\$ 12,370	3,678	\$ 265,359	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 625	\$ 625	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	560,220	560,220	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	13,255	13,255	7
8	Accounts Receivable (owners or related parties)	6,649	6,649	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 580,749	\$ 580,749	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	577,467	591,337	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	126,171	126,171	16
17	Accumulated Depreciation (book methods)	(48,552)	(60,754)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 655,086	\$ 656,754	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,235,835	\$ 1,237,503	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 570,247	\$ 570,247	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,614	26,614	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,126	14,126	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,325	30,325	32
33	Accrued Interest Payable	6,909	6,909	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	19,421	19,421	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 667,642	\$ 667,642	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	109,799	109,799	40
41	Bonds Payable	551,826	551,826	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 661,625	\$ 661,625	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,329,267	\$ 1,329,267	46
47	TOTAL EQUITY (page 18, line 24)	\$ (93,432)	\$ (91,764)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,235,835	\$ 1,237,503	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (35,093)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (35,093)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(58,338)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (58,339)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (93,432)	24

Operating Entity Only
* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,300,283	1
2	Discounts and Allowances for all Levels	(2,700)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,297,583	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	373,095	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 373,095	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	135,459	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,273	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	212,464	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	55,877	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 408,073	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,316	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,316	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	662	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 662	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,083,729	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	553,843	31
32	Health Care	1,556,057	32
33	General Administration	453,098	33
	B. Capital Expense		
34	Ownership	326,295	34
	C. Ancillary Expense		
35	Special Cost Centers	189,438	35
36	Provider Participation Fee	63,336	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,142,067	40
41	Income before Income Taxes (line 30 minus line 40)**	(58,338)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (58,338)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Entity is a cash basis taxpayer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,822	2,822	\$ 51,641	\$ 18.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,949	5,500	138,103	25.11	3
4	Licensed Practical Nurses	17,483	17,921	314,463	17.55	4
5	CNAs & Orderlies	48,887	52,206	421,624	8.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	873	947	20,757	21.92	9
10	Activity Assistants	418	418	2,995	7.17	10
11	Social Service Workers	2,638	2,638	56,725	21.50	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,609	16.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,077	12,524	90,376	7.22	15
16	Dishwashers					16
17	Maintenance Workers	2,379	2,379	34,852	14.65	17
18	Housekeepers	10,031	10,447	90,733	8.69	18
19	Laundry	3,702	3,753	22,781	6.07	19
20	Administrator	2,080	2,080	57,197	27.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,881	2,881	37,091	12.87	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	542	542	3,746	6.91	31
32	Other Health Care: Care Plan Coordinator	2,091	2,091	20,000	9.56	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,934	121,229	\$ 1,397,693 *	\$ 11.53	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	65	\$ 2,887	1,3	35
36	Medical Director	Monthly	8,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,521	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	65	\$ 12,408		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	n/a	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Molly Hawk	Administrator	0	\$ 57,197	Workers' Compensation Insurance	\$ 29,690	IDPH License Fee	\$ 1,303		
				Unemployment Compensation Insurance	84,473	Advertising: Employee Recruitment	586		
				FICA Taxes	101,730	Health Care Worker Background Check			
				Employee Health Insurance	12,859	(Indicate # of checks performed 171)	2,050		
				Employee Meals	3,361	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	527		
				Employee Relations	5,536				
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 57,197			Home Office Allocation	1,601		
B. Administrative - Other									
Description			Amount			Less: Public Relations Expense	()		
Managelment Fee Expense (eliminated in Col. 7)			\$ 58,000			Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 58,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 237,649	TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
Anschuler, Melvoin & Glasser, LLP	Accounting	\$	1,600	N/A		\$	Out-of-State Travel	\$	
LTC Solutions	Computer Services		3,170						
Computer Rescue	Computer Services		590						
Expert Computer Repair	Computer Services		94				In-State Travel		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Seminar Expense		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,454				Home Office Allocation	806	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 806	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Petersen Health Care, Inc. (Vandalia)
Provider Number - 0047583
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3) 5,454

Allocated from Home Office

Other Professional Fees	6,649
Legal	89
Other Professional Fees - PHO	2,738
Legal - PHO	84
	<u>9,560</u>

Total (agree to Schedule V, line 19, column 8) 15,014

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7								N/A					
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		Vandalia Rehabilitation & Health Care Center		STATE OF ILLINOIS	#	0047589	Report Period Beginning:	01/01/2006	Ending:	12/31/2006	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report?			<u>No</u>							
	If YES, give association name and amount.			<u>N/A</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>No</u>							
	If YES, have these costs been properly adjusted out of the cost report?			<u>N/A</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			<u>No</u>							
	If YES, what is the capacity?			<u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases?			<u>Yes</u>							
	What was the average life used for new equipment added during this period?			<u>5 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>2,527</u> Line <u>10A</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			<u>Yes</u>							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			<u>No</u>							
	If YES, give effective date of lease.			<u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES NO <u>X</u>							
	If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.			\$ <u>63,336</u>							
	This amount is to be recorded on line 42 of Schedule V.										
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?			<u>No</u>							
	If YES, attach an explanation of the allocation.										
SEE ACCOUNTANTS' COMPILATION REPORT											
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>Yes</u>							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?			<u>No</u>							
	For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.										
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.			\$ <u>3,361</u>							
	Has any meal income been offset against related costs?			<u>Yes</u>							
	Indicate the amount.			\$ <u>4,273</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			<u>No</u>							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			<u>No</u>							
	If YES, please indicate the amount of income earned from such a program during this reporting period.			\$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>N/A</u>							
	d. Have vehicle usage logs been maintained?			<u>Adequate records have been maintained.</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training?			<u>No</u>							
	Indicate the amount of income earned from providing such transportation during this reporting period.			\$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm?			<u>Yes</u>							
	Firm Name:			<u>Ginoli & Co</u>							
	The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?			<u>No</u>							
	If no, please explain.			<u>Audit currently in progress</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?			<u>No</u>							
	Attach invoices and a summary of services for all architect and appraisal fees										